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Article *in* British Journal of Psychotherapy · November 2006

DOI: 10.1111/j.1752-0118.1999.tb00473.x

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COGNITIVE-ANALYTIC THERAPY FOR BORDERLINE PERSONALITY DISORDER IN THE CONTEXT OF A COMMUNITY MENTAL HEALTH TEAM: INDIVIDUAL AND ORGANIZATIONAL PSYCHODYNAMIC IMPLICATIONS

Ian B. Kerr

ABSTRACT Given that borderline personality disorder (BPD) is increasingly managed by community mental health teams (CMHTs), an exploration of the effectiveness of the cognitive-analytic model (Ryle 1997a) was undertaken in this context. A young man with a primary diagnosis of BPD was offered a course of cognitive-analytic therapy (CAT) by a member of the CMHT. Therapy was only partially successful, due apparently to the severity of the disorder but also, critically, to the absence of a shared understanding of the disorder by team members as well as other agencies involved. However, the CAT model, involving explicit reformulation, helped educate key members of the team about the disorder and the part they might play in it and to contain the splitting and anxiety provoked by such a patient. In addition, CAT created a reasonably robust therapeutic alliance, with more regular contact and no re-admission during the period of therapy. An extended `contextual' reformulation can also offer a means of understanding the difficulties encountered in working with such patients, classically described by Main in `The ailment' (1957), and provide the conceptual containment required to work with such `difficult' patients.

Introduction

Borderline personality disorders (BPD) constitute a difficult and possibly increasingly common (Millon 1993) group of patients to understand, treat and manage, and hitherto treatment approaches, including pharmacotherapy, have been generally rather disappointing. The topic is complicated by the limitations of a categorical approach to diagnosis and the undoubted underlying heterogeneity of these disorders both in terms of aetiology and severity. These disorders have been extensively reviewed from various aspects in Paris (1993) and their psychodynamic conceptual history by Bateman (1991). There still exists considerable debate about the psychological nature of these disorders which has tended to polarize around `conflict' and `deficit' theories of aetiology (reviewed in Bateman & Holmes 1995). The former would be exemplified by the work of Kernberg and in general those working within the Kleinian tradition, whilst the latter, generally ascribing critical aetiological importance to real experience of adversity or abuse, would include those working in the self-psychology tradition of Kohut, the `Independent' analytic school and the cognitive-analytic therapy (CAT) model developed by Ryle. Perhaps a consistent and common theme to this debate would be the notion of failure of integration of `ego' or `self' states, the anxiety generated thereby and, strikingly, the failure to be able to reflect upon such states of

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British Journal of Psychotherapy, Vol 15(4), 1999
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mind in self or, empathically, in others. Such failure is also addressed by the notion of reflective self-capacity (Fonagy 1995) which is described as being a protective factor in the face of adversity or abuse. Arguably the 'conflict'-'deficit' debate represents essentially debate regarding the primary or secondary nature respectively of such pathology. This pathology has also been described in terms of abnormalities of adult attachment style (Fonagy *et al.* 1996; Patrick *et al.* 1994), some features of which, for example, `enmeshed' and generally chaotic interpersonal styles, are very apparent in such patients. The failure to develop an integrated ego or self state may also have at least a partly biological basis given the evidence for abnormalities of impulse control (Stein *et al.* 1993; Paris 1993). This may be an important vulnerability factor in the context of subsequent adversity or trauma, for example, sexual abuse, which has been increasingly implicated (Stone 1993). Such disorders have thus also come to be conceptualized in part as a `complex' post-traumatic stress disorder (Herman 1992). A further key feature of such disorders would be, arguably, damage to individual development or `individuation' (see Samuels 1985).

In general such patients present with considerable morbidity and are high consumers of resources in both psychiatric and primary care settings where they have usually been viewed as `hard to help' or `difficult' due to their provocative and alienating behaviours. Although modified forms of analytic psychotherapy have been advocated for these disorders (Higgitt & Fonagy 1992; Stevenson & Meares 1992), in practice they are rarely referred to or seen in psychotherapy outpatient departments nor are they regarded as good candidates for psychotherapy. More recently some success in treating these disorders has been reported using cognitive (Perris 1994), intensive cognitive-behavioural (Linehan 1993), or cognitive-analytic therapies (Ryle 1997a). The use of the latter in the treatment of BPD and its theoretical basis has been already extensively described (Beard *et al.* 1990; Ryle & Beard 1993; Ryle 1997a, 1997b). Both its time-limited nature and its theoretical basis as well as its efficacy appear to offer important options in the understanding and treatment of such disorders, especially in institutions with limited resources such as the NHS and, in particular, the community mental health teams (CMHTs) to which responsibility for most routine care for severe mental disorders is being devolved.

These teams face enormous pressures, bearing responsibility for large numbers of psychiatric patients and having limited back-up facilities in terms of specialist psychotherapy services, whether in the form of traditional outpatient services or in residential centres such as therapeutic communities. In addition, staff are rarely trained specifically to deal with complex personality disorders. Thus the presentation of patients with such disorders, although they are well recognized to complicate the majority of all psychiatric conditions, constitutes a major challenge and stress to such teams and to their parent institutions.

This paper describes an attempt to treat and manage one such patient in a community context (in the absence of any other immediate therapeutic options), using the theoretical and practical model of borderline disorder offered by CAT. The background to this model as well as its characteristic use of the joint 'tools' of diagrammatic and written reformulations (the latter including listing of key 'target problem procedures' and therapeutic 'aims') are fully described in Ryle (1995). The difficulties encountered in treating such a patient in this context with this model will be discussed below as well as the lessons learnt and apparent advantages offered by it, particularly in terms of the collective function of the CMHT and associated agencies.

Case History

The Course of Therapy

'Oh - he's just a little boy who's never been loved...'

I first met B when he presented to the CMHT base for `emergency' attention to a variety of complaints. These included not being able to cope with life, bad feelings which were `doing his head in' and suicidal thoughts. He was also complaining of a lack of cash and housing difficulties and demanding a further prescription for Valium and painkillers for a recent crush fracture of his lower lumbar spine. This he had sustained when he jumped downstairs following an argument with his girlfriend. He also had a long history of self-harming by taking overdoses, some of which had been seriously life-threatening and had resulted in his admission to medical wards for intensive treatment. I suspected that he had had a drink although he strenuously denied this. He had been due to see me for a formal appointment a few days earlier but had not managed to attend due to a complicated set of `circumstances'. On that occasion his distress was taken seriously enough by the team to have him admitted to the ward. There, however, he rapidly became more demanding and disgruntled and when he came in the next day intoxicated and got into an argument he took his own discharge. This was a pattern of admission and self-discharge which, according to his notes, had been going on for several years without any essential change or improvement. We had been warned by the referring team of this pattern of behaviour and distress and we had had intimation of the hostile and punitive responses he could elicit from the notes in his file. Some went as far as to suggest that he was actually malingering and had no psychological disorder at all, and that, given his aggressive outbursts, he should be sent packing. However it seemed even from the brief encounter we had that there were indeed significant psychological issues underlying his history which might benefit from an intervention such as CAT, if he was motivated enough to use it.

His early history, briefly, included illegitimacy, disturbed early relations with a drug-abusing mother and subsequent hardship suffered at the hands of a harsh stepfather, as well as serious subsequent difficulties at school. Later delinquent behaviour had led to him being sent to prison for several months which had, it appeared, been a traumatizing and alienating experience, confirming, of course, many of his preconceptions about the hostile nature of the world. He also had a history of poor concentration and impulsivity which, despite his apparent intelligence, had contributed to a difficult career at school culminating in his expulsion. Clinically he presented with features of all nine of current DSM IV diagnostic criteria as well as the typical, rather `existential' type of empty depression characteristic of this syndrome and also a history of intermittent drug and alcohol abuse. Although severity of disorder is not currently formally assessed by DSM criteria, he certainly appeared to suffer from a serious and long-standing disorder.

Our initial sessions were relatively quiet and apparently productive, as he talked through his situation, his background and current problems and anxieties, and probably constituted a rather idealized `honeymoon' period. (This pattern of idealizing behaviour he was himself quickly able to describe on his initial sequential diagrammatic reformulation (SDR) (see Figure 1)). Nonetheless, they too were characterized by his continuing demands that I should somehow help magically to sort

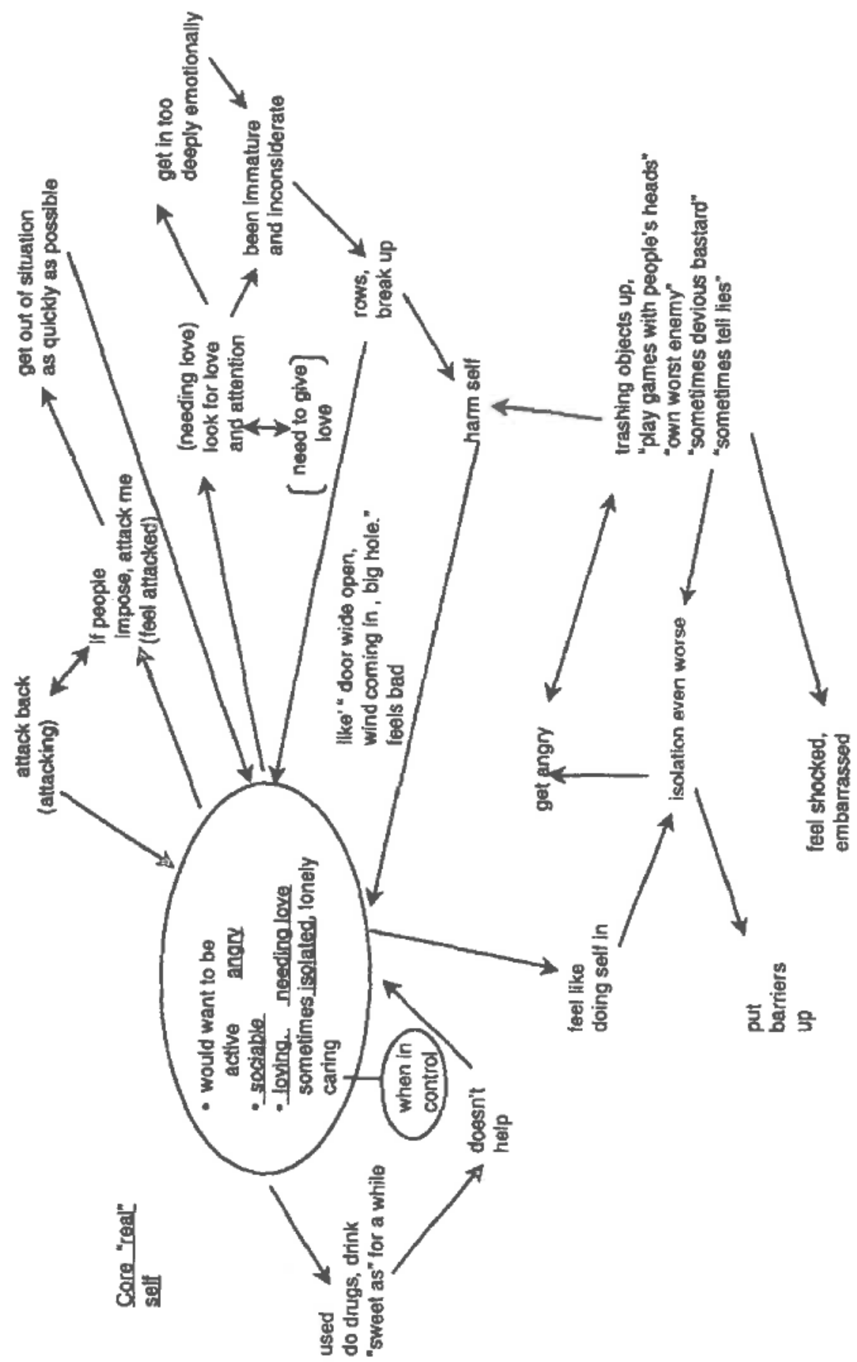

Figure 1 Initial 'rough draft' of sequential diagrammatic reformulation (SDR) sketched together with patient

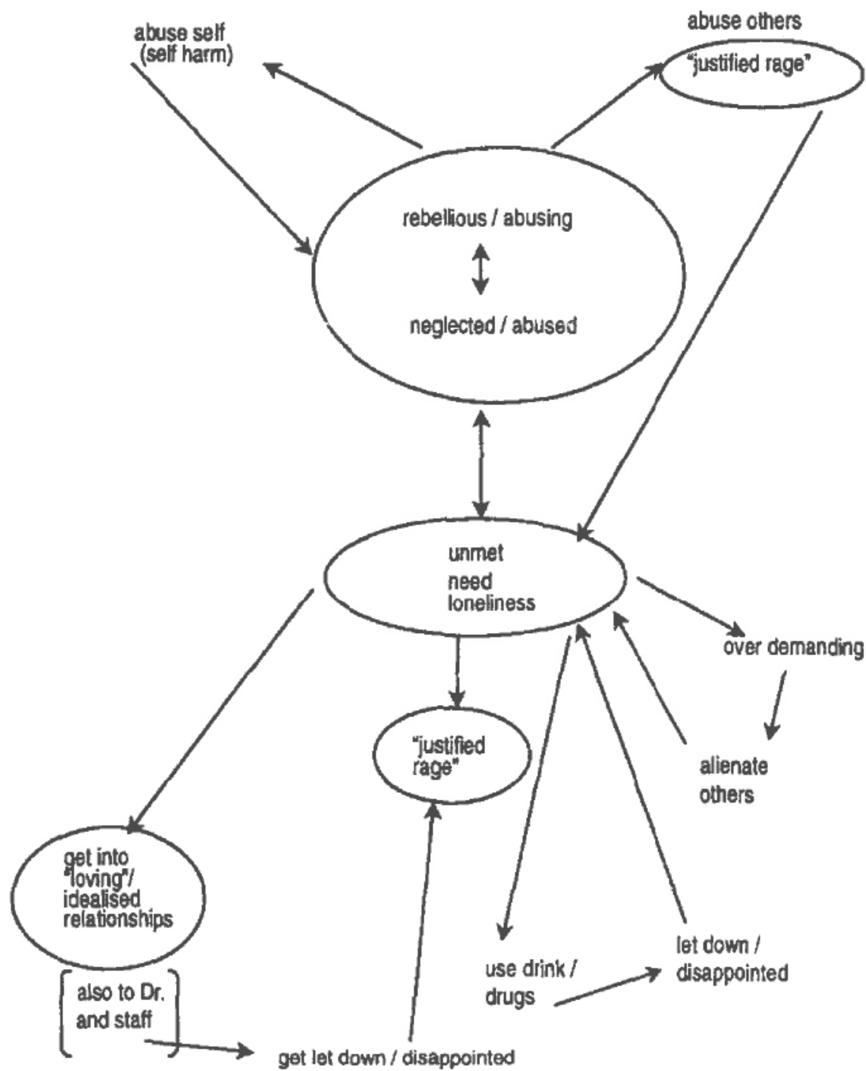

Figure 2 Simplified SDR used with patient highlighting possible split self-states (circled) and reciprocal role procedures (RRPs

out his problems in living. His timekeeping and attendance quickly began to be erratic, and when he did turn up late or on the wrong day he would aggressively demand to be seen. This pushing of limits was very persistent and made it throughout very difficult to settle down to regular work. It was compounded by very real difficulties in his life, such as racial harassment due to his skinhead appearance living in a predominantly black estate, threat of eviction from his council flat, cash shortages and his intermittent use and abuse of alcohol and drugs including the tranquillizers and painkillers he was prescribed by various doctors.

Nonetheless, I felt that we had achieved some degree of therapeutic alliance quite early on, helped considerably, I think, by his encountering the explicitly nonjudgmental and collaborative therapeutic attitude central to the practice of CAT. This appeared to be something (a `role') he had not encountered before and which he appeared to respond positively to. The fact that we engaged very early in trying to make sense of what was going on and why, especially in trying after only a few sessions to sketch a reformulation diagram (see Figure 1), contributed, I think, greatly to this and appeared to have the effect of engaging and containing him. There seemed to be underneath this awkward and hitherto frightening patient quite a frightened little boy whose needs had never been adequately met and whose capacity to acknowledge and describe much of his maladaptive and self-destructive behaviour I found really very endearing and engaging. It seemed that this capacity was something he had retained and enabled him, for example, to have engaged several girlfriends over the years in what sounded rather a maternal fashion.

As is generally recommended with such patients (Ryle 1997b), we attempted to do a diagrammatic reformation early on. Both the initial, rather disorganized but, for him, apparently powerful and meaningful version, as well as the more simplified one describing key patterns and self-states and emphasizing more clearly his repertoire of reciprocal roles and self-states, are shown (see Figures 1 and 2). Although the (third) session when we did this initial work seemed very productive and collaborative, he seemed to find it hard subsequently to retain interest in the diagram and indeed he managed to `lose' the first (and subsequent) copy of it somewhere at home. Our subsequent written reformulation (not reproduced here) and diagram (see Figure 1) include descriptions of his personal background and history, target problem procedures (TPPs), principal self-states and reciprocal roles. The latter included most notably and characteristically roles around an abused/neglected-abusing/ rebellious axis. A central difficulty (described in the written reformulation) concerned uncertainties about self-identity (which might be described in terms of a failure of individuation) in addition to the self-state splits characteristic of borderline disorder. Both verbal and diagrammatic reformulations also described his use of drink and drugs to cope with mood swings (associated with self-state shifts) and also his paranoid tendency to blame others for his 'real' problems (thus pre-empting to a large extent any serious attempt to change himself). These two problems arguably account in large measure for the relative failure of his therapy.

He continued to turn up for subsequent sessions although rather irregularly and often with complaints about life in general. When we met we did discuss present difficulties, for example with his girlfriend and with the hassles of street life, but we also talked through to some extent his earlier childhood experiences and more recent problems. This included the death of a close friend who had had AIDS and also his own worries that he might be HIV positive.

However, his frequent turning up to other agencies (such as housing officers, a friendly solicitor, other doctors, social workers and so forth) resulted in a stream of phone calls and requests for documentation which became very exasperating given the work I myself was trying to do, but which in this way he kept sabotaging. Such chaotic help-seeking behaviour seemed a good example of disturbed and insecure attachment behaviour. Thus he recurrently managed to fill me with anger and frustration both with him, and also at the system, when I got such calls from other irate professionals attempting to help him or being abused by him. My reactions, on reflection, seem a good example of the `concordant' and `complementary' countertransference responses described initially by Racker (1968) and elaborated more recently in CAT theory in terms of `identifying' and `reciprocating' responses (Ryle 1997b and see Figure 3). Towards the end of therapy, this state of affairs had finally begun to exasperate (and `abuse') me to the extent that I began to feel at times rather hopeless and fed up with him, and impatient finally to terminate our sessions.

At other times he could also be extremely intimidating, for example, to reception staff. This resulted on one occasion in him being forced to wait outside the building until I arrived. Interestingly, however, we were able to share his SDR with our receptionist who declared immediately *'Oh - he's just a little boy who's never been loved'.* She proceeded thereafter to treat him essentially like a needy young child, even offering him cups of tea when he had to wait, thus avoiding falling into the expected punitive reciprocal role! This sort of understanding gradually began to permeate various members of the team, including the nursing team leader, the other doctors and, notably, the team secretary who treated him essentially as did the receptionist. This seemed to have a generally de-escalating and containing effect on our collective dealings with him. Unfortunately and frustratingly this understanding did not extend beyond the immediate team and a striking and recurrent phenomenon was the way in which other colleagues or professionals elsewhere would project onto me their irritation and frustration at him, as if I personally were to blame. This in turn left me feeling angry and abused and came to be a familiar and thought-provoking occurrence over these many months.

One of the final straws in the way of trying to work regularly with him occurred when he turned up to Casualty in some distress and seeking help, saying that he had a weapon in his bag and demanding to be let in immediately. He was immediately banned from the entire hospital which meant that for several weeks our sessions were actually stopped before an alternative arrangement could be set up. However, he turned up for only two of these final half-dozen sessions, one out of hours when I saw him very briefly. This may have reflected a reluctance to acknowledge that I would no longer be seeing him and not be his personal doctor and magical sorter-out of his continuing `real' needs. Overall, we ended up having a total of some 29 `sessions' over a period of about 36 weeks, given these various disruptions, and this does seem very indicative of the chaotic nature of this therapy overall.

I was able to arrange one last follow-up meeting six weeks after this. Sadly, he used most of the session to demand angrily that I admit him to hospital in order to sort things out. We had thus been 'unable' to address termination or the doing of `goodbye' letters (both key features of CAT), and he certainly seemed unable to acknowledge anything that we might have done together at that time. Arguably this behaviour represented an angry and rebellious reaction to my apparent `neglect' of him and also perhaps a defence against the painful and uncertain isolation and

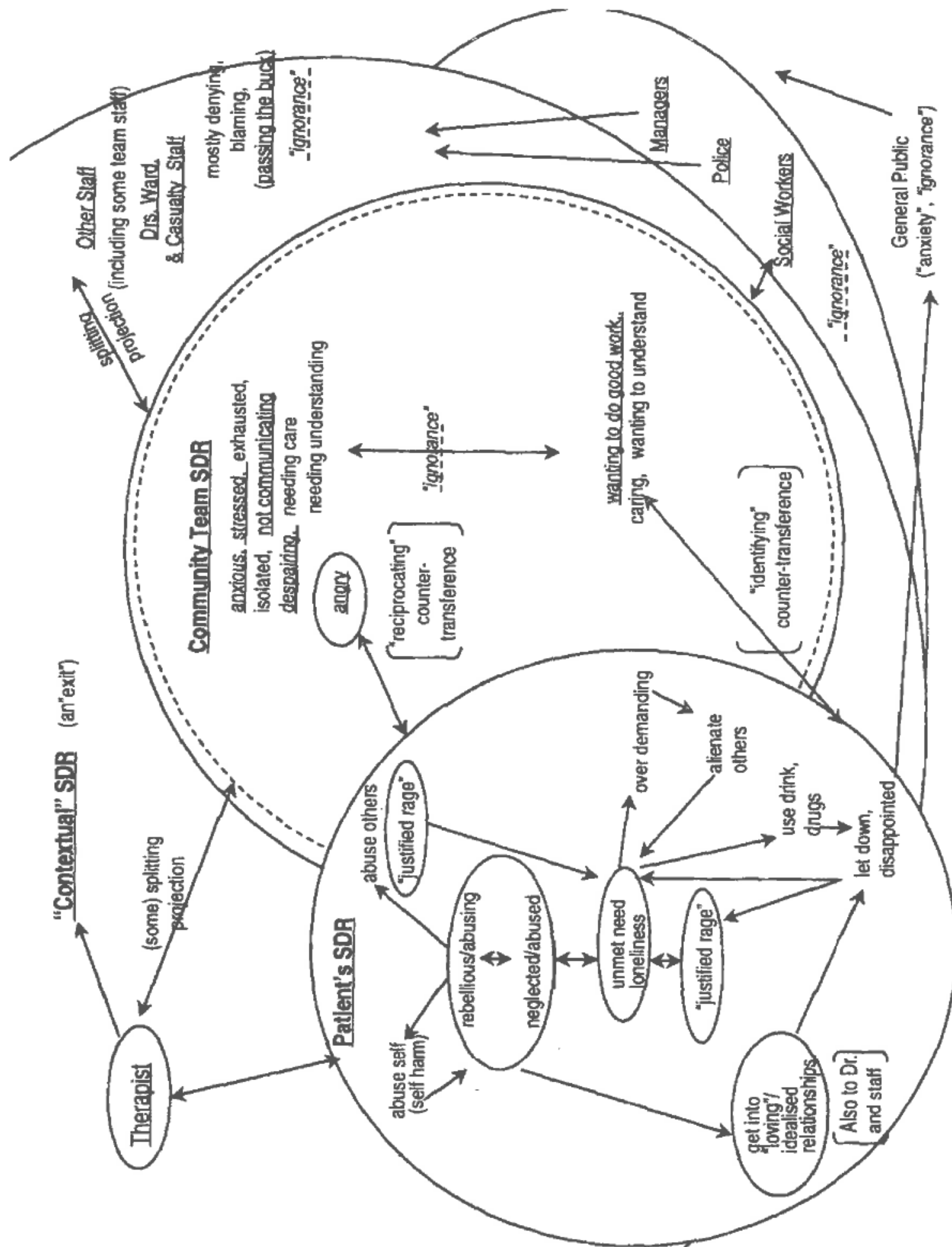

Figure 3 Extended complex 'contextual' SDR incorporating patient's previous SDR and community team 'self-state' diagram with collective RRPs and countertransference responses to the patient's self-states and roles. Further outer layers include states and roles of other hospital staff groups, other services, managers and the 'general public'. 'Institutional anxiety' and 'ignorance' are virtually ubiquitous. Descriptions also found in Main are underlined.

abandonment which our termination might appear to mean for him. This seemed confirmed a month later when I heard from a team member that he was very 'grumpy' and greatly upset about my no longer seeing him.

The Outcome of Therapy

During this therapy we were able to do the initial work of reformulating and there is evidence that he heard and responded to this and was also able to talk through to some extent many of the difficult and painful experiences of his past and recent life which he had not previously been able to do. Furthermore, during this period he did attend our sessions, even if rather irregularly, and did not generally bother emergency clinic staff out of hours nor, most significantly perhaps, was he re-admitted to hospital. (He had been admitted several times a year prior to this period.) The feed-back from the CMHT nursing team leader suggested that it had become much more possible to work *with* him and that he had much more insight into the patterns of his own thought and behaviour. He had been briefly re-admitted to hospital elsewhere and found to his distress that the team there did not ` understand' him in the same way. This did seem an indication of progress with his own team, by whom he had previously been considered to be unmanageable. An important contribution to his management appeared therefore to have been the introduction of a conceptual framework within which the team could think about such disorders. This seemed particularly well exemplified by the comment and changed behaviour of the receptionist. However, further recent, albeit brief, hospital re-admissions indicate that very radical changes in his overall mental state have not been achieved, and the possibility of a serious selfharm attempt succeeding or drug abuse becoming ultimately chronic would still appear to be very real.

Discussion

Reasons for the Relative Failure of Therapy: The Patient

On the face of it, this therapy, which was extremely stormy and difficult for both therapist and patient in both a practical and psychological way, would appear to have been at best a very partial success, in that neither significant and lasting changes in the 'structure' of his inner world nor in the distress and dysfunction experienced in his day-to-day living seem to have occurred. However, this intervention did at least enable much more regular contact and support for the patient than had previously been the case and prevented any further re-admission to hospital during the period of therapy. It is well recognized in psychotherapy that, although not always immediately obvious or easy to assess, the seeds of the possibility of future change may still be sown during such an encounter. The early Freud (1905), however, who regarded a 'reliable character' as a prerequisite for a successful analysis, would undoubtedly not have taken on such a patient in the first place!

The nature of change occurring during and after therapy, as well as the notion of resistance to it, has generated a considerable literature from various theoretical viewpoints (see review by Strand and Benjamin 1997). From the more purely cognitive stance of the ' transtheoretical' model of Prochaska, Norcross and DiClemente (1994), this patient probably did not move much beyond a state of 'precontcmplation'. Psychodynamic concepts addressing this problem have included

those of the `negative therapeutic reaction', `repetition compulsion' and the existence of ` pathological organizations' (see Bateman and Holmes 1995; Steiner 1990). It has been argued that these notions, as well as those such as projective identification (Ryle 1994), deriving from a model of (at times apparently `motivated') intrapsychic conflict and defence, can be constructively re-interpreted from the CAT model in terms of persistence of a narrow range of early interpersonally-derived reciprocal roles (Ryle 1994). Thus, resistance to change, along with the associated notion of poor motivation, can be described in terms of the patient's repertoire of maladaptive reciprocal roles being confirmed if others (including the therapist) collude with them and so perpetuate and possibly exacerbate them. From this perspective it is an important part of the therapist's job to defuse the power and `compulsiveness' of such ` roles' by joint work with the patient on their recognition and by developing higher order capacities for self-reflection (level 3 in Ryle's model (1997a)). The importance of therapeutic sensitivity to such role-playing in relation to the countertransference was in fact discussed several years ago by Sandler (1976). The notion of working towards structural psychological change in what Vygotsky described as the `zone of proximal development' is central to CAT theory and its practice of working *with a* patient by means of the jointly constructed reformulation. The importance of working in this `zone of proximal development' is also alluded to by some psychoanalytic writers (Fonagy 1995), although the therapeutic implications of working more proactively and collaboratively with the patient do not appear to have been followed through explicitly.

In the case of my patient, it is arguable that I became involved in a largely unwilling collusion with his continuing perception ('role') of being neglected and misunderstood, thereby justifying his continuing rebellious and abusing stance toward authority figures. His ' needy'/'victim' role (also described on the SDR) continued to define his main relationship with myself and psychiatric services. He was only partially able to reflect on his self-states and problematic procedures and on his continued, associated substance abuse to deal with feelings of distress and emptiness. This, together with the hopeless prospects which his (real) life circumstances offered, were major obstacles to therapy. It could be argued that a longer period of treatment would have had greater success, although it is not clear that this would have been possible either from his position or that of a therapist working in these circumstances.

Reasons for the Relative Failure of Therapy: The Context

However, it increasingly came to seem that an important set of factors which militated against the `success' of this therapy, however defined, was the circumstantial and organizational context within which it took place. In considering this I re-read Main's (1957) classic article `The Ailment' on his group of `special' patients and the effect they had on staff with an increasing sense of *`déjà* vu'. It seemed that he was actually describing my patient and the complex group and institutional dynamics surrounding therapy. In many ways this paper is an attempt to reconsider Main's work in the light of my own experience and from the theoretical perspective (CAT) within which it was attempted. His work on unconscious processes operating in psychiatric hospitals, their effects on staff and the possible role of psychotherapists in them has of course been developed and refined by writers such as Hinshelwood (1994) and, in the particular context of BPD treated in a day hospital, by Bateman (1995). 1 was also stimulated by

a paper describing the application of the CAT model to a dysfunctional organization (a hospital surgical unit) which considered similar problems in a parallel way, albeit with a focus on the organization firstly and only secondarily on the psychology of the individuals within it (Walsh 1996). In the context of our CMHT and this patient, the focus has been rather more the relationship between a mentally disordered ('dysfunctional') patient and an arguably also significantly dysfunctional organization (a district mental health service). This then seemed to extend in turn to a wider context of other agencies beyond, ultimately including the amorphous but real presence of the public at large. Thus Walsh's approach prompted the attempt to describe diagrammatically a possible description of what was going on contextually around this patient (Figure 3).

Main's patients, described as being diagnostically heterogeneous, would probably now be diagnosed as suffering from borderline personality disorder. All appeared to suffer considerable distress and to seek help in a chaotic and disordered fashion. Their lack of reflective self-capacity and poor integration of self-states elicited very different reactions from staff members. These appear to fall largely into two principal categories, one consisting of 'heroic-empathic-caregiving' and another which appears `punitive and denying of the reality of the patient's distress'. From a CAT perspective these could be described as the enactment of reciprocal role procedures on the basis of identifying and reciprocating countertransference responses to the patients' `needy/ abused/distressed' and 'angry/abusing' roles. The most perplexing and frustrating feature of these patients is their shifts between different self-states and role procedures. Partially dissociated self-states and the inability to reflect upon them are, in Ryle's model, described as a core characteristic feature of BPD. This in turn promotes split responses from those involved who are unable to understand or themselves integrate these disparate features of psychopathology. The results of this are sensitively and comprehensively described by Main in terms of the strain, stress, anxiety, anger, despair and so on experienced by the nursing team as well as the denial and blaming (' passing the buck') occurring consequently between various professionals. Finally the ` justified' hopelessness and sense of failure which is ultimately reached after protracted running around the ridges is wearily documented, as is the poor outcome for the majority of these patients. This description resonated powerfully for me in terms of my own experience with B. What Main from his contemporary analytic perspective was not able to do, however, was to describe such psychopathology in terms of a model of an individual disorder (almost certainly borderline or 'self-state' disorders) nor, more importantly, from the point of view of this discussion, to offer an accessible description of individual psychopathology linked with an understanding of the reciprocal role relationships which staff were drawn into, on the basis of which containment might have been achieved. In the present case I felt that the use and sharing of my patient's reformulation in the CMHT did in fact have some such effect, although, as noted, this was vitiated to a considerable extent by the effects of involvement (with the considerable effects described by Main) with other professionals and agencies.

In her study of the construction of an SDR in a dysfunctional organization, Walsh stresses that it is possible in this manner to describe aspects of an organization in terms of individual and organizational 'object relations' and she reports the beneficial effects of so doing. These include, in her view, its being containing, educational, nonjudgmental and enabling of communication. To this one might add that it permits the

acknowledgement and owning of the powerful, primitive feelings elicited by such a patient (and by colleagues' actions), as well as the considerable anxiety associated with the failure to deliver `good' treatment. The powerful role of anxiety and the primitive nature of its associated actions are arguably rather under-emphasized in CAT theory, although central in varying degrees to most analytic (especially Kleinian) thinking. Walsh, however, also warns against the dangers of reducing the political to the psychological, and reminds us that a bad organization also needs reorganizing. The need to understand the overlap and interplay between individual and organizational learning has also been stressed by Kim (1993).

Drawing on this work, an attempt was made (Figure 3) to extend my patient's SDR into a 'contextual' one involving putative, although mostly very clear, reactions from the different professionals involved in his care. This described the reciprocal role patterns being enacted and suggested why and, importantly, showed how they interact with each other. Furthermore the core states of both patient and staff are described in what is a non-judgmental and educative manner. Overall this approach hopefully permits, as Walsh puts it, the clear ' establishment of causality' in this situation. In addition, the key features of Main's description of his 'special' patients and staff 'ailment' can also be essentially described on the same diagram, in several places using his own words. It can be seen that such a diagram has much in common with systems-based understandings employed, to varying extents, in both family and group therapies. However the CAT model offers in addition, and critically, an explicit psychodynamic account of the behaviour of individuals involved, in terms of enactment of reciprocal roles and the existence of maladaptive procedures and split self-states.

Thus, it may be that it is possible to venture some sort of reply belatedly to Main when he asks firstly why these patients are 'special', by suggesting that they were suffering from what would now be described as a form of disorganization and distress diagnosed as borderline personality disorder. Secondly, when he wonders what the staff 'ailment' is which develops in trying to work with them, it might be suggested that this is, effectively, the unwitting, contextual or organizational 'ignorance' of the various effects these patients may have on staff involved. These would be described from the CAT model as countertransference responses understood as elicited reciprocal roles. Such 'institutional ignorance' might be described as having a direct parallel with the similarly unwitting ' institutional anxiety' described by MenziesLyth (1959) in her pioneering studies. Finally, in response to Main's admonition about not giving advice to colleagues also involved with such patients, one might now however suggest constructing a 'contextual' or organizational diagrammatic reformulation to be shared with all involved, including the patient. It is likely that a less complex version that the extended one generated here (Figure 3) would be just as helpful in identifying and explaining key features of interactions between patient and staff and others. In the absence of some such measure it seems likely that any therapeutic intervention will be doomed to founder. Thus, an important feature of the 'secure base' which staff might offer such very disturbed patients would be a shared, non-collusive understanding from all staff members.

It does seem likely, however, that the work of containing and working with such highly disturbed patients may need to be undertaken in a setting such as a therapeutic community. There is already good evidence for the efficacy and cost-effectiveness of such units in treatment of personality disorders (Menzies *et al.* 1993), and the use of

the CAT model as a conceptually-containing, common house language would arguably aid such work even further. Use of this model is in fact currently being evaluated with promising results in a day hospital/therapeutic milieu setting (Kerr *et al.,* in preparation) and a report of its general application in care planning for personality disorders in a district service has also recently been made (Dunn & Parry 1997).

It would appear that the extension of such approaches, in particular the creation of a simple `contextual reformulation' describing institutional or organizational responses which undoubtedly exist, even if unrecognized, in both mental health care services and primary care settings, could be of considerable usefulness. Treating such patients and avoiding further damage to them requires support and education for staff, recognized in itself to be a problematic area (Goldberg & Gater 1996). It seems likely that such approaches could also be helpful in treating and managing other disorders (for example, somatoform or eating disorders) where the responses of staff and others may be important in maintaining or exacerbating the disorder. The application of the model and methods described here clearly requires further controlled evaluation, ideally in comparison with the other therapeutic approaches discussed above.

Acknowledgement

I am indebted to Dr Anthony Ryle for initial supervision of this case and, subsequently, for helpful comments on the paper.

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